DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL
ADVISORY COMMITTEE FOR INJURY PREVENTION AND CONTROL

Advisory Committee for Injury Prevention and Control

DoubleTree Hotel Atlanta – Buckhead
Minutes of the Forty-Seventh Meeting
June 13-14, 2006

Summary Report

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The forty-seventh meeting of the Advisory Committee for Injury Prevention and Control (ACIPC) took place on Tuesday, June 13, 2006, from 1:00 p.m. to 5:15 p.m., and Wednesday, June 14, 2006, from 8:30 a.m. to 11:30 a.m., with Dr. Carolyn Fowler serving as Chair.

The fifteenth meeting of the Science and Program Review Subcommittee (SPRS) took place on Monday, June 12, 2006, from 6:30 p.m. to 9:30 p.m., and Tuesday, June 13, 2006, from 8:30 a.m. to 9:45 a.m., with Dr. Mark Redfern serving as Chair.

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Tuesday
June 13, 2006

General Session (Closed to the Public)

Presentation of Recommendations from SPRS
Vote on Results of Secondary Review

Dr. Carolyn Fowler, Chair of the Advisory Committee for Injury Prevention and Control (ACIPC), called the meeting to order at 1:08 p.m. **Ms. Louise Galaska**, Executive Secretary of ACIPC, greeted the group and provided housekeeping announcements.

Dr. Rick Waxweiler, Associate Director for Extramural Research
National Center for Injury Prevention and Control (NCIPC)
Centers for Disease Control and Prevention (CDC)

Dr. Rick Waxweiler explained that one of the purposes of the Science and Program Review Subcommittee (SPRS) is to perform a secondary review of the grant applications responding to NCIPC's Program Announcements that have been recommended by NCIPC staff for further consideration for funding. Secondary review is a review and discussion of the programmatic merits of each application. It is not another peer review for scientific and technical merit. The primary external review is conducted by the Initial Review Group (IRG), which is similar to a Study Section at the National Institutes of Health (NIH). He explained that before voting on each Request for Applications (RFA), ACIPC members who are involved with, or have a financial stake in, the universities under consideration would be asked to recuse themselves from voting on that Program Announcement.

Dr. Mark Redfern
University of Pittsburgh
Chair, Science and Program Review Subcommittee (SPRS)

R49 Grants: Investigator-Initiated Grants

Dr. Mark Redfern explained the five RFAs under the R49 program:

- Unintentional injury
- Dissertation
- Traumatic Brain Injury (TBI)
- Violence prevention
- Care for acute injury

A total of 163 grant applications were received under the R49 grant program. Of those, 17 were deemed non-responsive. One hundred and forty six applications were peer-reviewed, 39 were triaged, or screened out of the review process, 107 were scored, and 101 applications scored better than 350.

Program Announcement #06001:
Research Grants to Prevent Unintentional Injuries

Dr. Flaura Winston recused herself.

Thirty grants were received under this Program Announcement. Five were non-responsive, 25 were peer-reviewed, six were triaged, 19 were scored, and 17 scored better than 350. NCIPC staff recommended, and SPRS concurred, that the applications with the two highest scores receive funding support. The third-ranked application would be skipped, and the fourth-ranked grant would be funded, for a funding total of $745,000. The rationale for funding the fourth-ranked grant was to achieve programmatic balance. The top three grants focus on traffic safety, where the fourth grant addresses parental supervision, an important research priority at NCIPC.

Moreover, only three points separate the scores of the third- and fourth-ranked applications, so the recommendation does not have an appreciable effect on the quality of the funded research. SPRS further recommended that if additional resources become available, the third-ranked grant and other applications with scores better than 250 be funded in rank order; however, if one-year funds become available, then staff and SPRS recommend considering funding the two one-year grants in this area. Of those two one-year grants, it is recommended that the grant from McDonnell receive priority, due to the importance of the topic area.

Motion

Dr. Hendricks Brown moved to approve the SPRS recommendations regarding funding for Program Announcement 06001. **Dr. Ralph Frankowski** seconded. The motion carried unanimously with no abstentions.

Program Announcement #06002:
Dissertation Grants for Violence-Related Injury Prevention Research in Minority Communities

Drs. Fowler and Winston recused themselves.

Dr. Redfern explained that 11 applications were received in this category. One was non-responsive, ten were peer-reviewed, seven were scored, and six of them scored better than 350. SPRS recommended funding the applications with the four highest-ranked scores.

Motion

Dr. Sheryl Heron moved to approve the SPRS recommendations regarding funding for Program Announcement 06002. **Dr. Fuzhong Li** seconded. The motion carried unanimously with no abstentions.

Program Announcement #06003:
Research Grants to Describe Traumatic Brain Injury Consequences

Drs. Winston and Fowler and Ms. Billie Weiss recused themselves.

Dr. Redfern said that ten applications were received under this Program Announcement. All ten were scored, and six of the applications scored better than 350. The application with the highest score is recommended for funding. Further, if additional resources become available, applications with priority scores of 250 or less should be funded in rank order.

Motion

Mr. Gerald Reed moved to approve the SPRS recommendations regarding funding for Program Announcement 06003. **Dr. Frankowski** seconded. The motion carried unanimously with no abstentions.

Program Announcement #06004: Violence-Related Injury Prevention Research

Dr. Redfern explained that 74 applications were received in this area. Nine were deemed non-responsive, and 65 were reviewed. Twenty-two were triaged out. Of the 43 applications that were scored, seven were recommended for funding.

Drs. Heron, Winston and Dr. Redfern recused themselves. Dr. Brown temporarily served as Chair.

Dr. Brown noted that the funding streams are separate under this announcement, so applications are recommended according to their funding stream. The Youth Violence funding stream does not currently have support. SPRS recommends that the applications with the seven highest-ranked scores be funded in accordance with the availability of funds in the following three funding streams:

- Child Maltreatment
- Domestic Violence/Sexual Violence
- Suicide

An appropriation of sufficient funds to support applications in the area of Youth Violence was anticipated when the Program Announcement was released. The proposed funding total for the seven recommended applications is $1,925,311.

Motion

Dr. Li moved to approve the SPRS recommendations regarding funding for Program Announcement #06004. **Dr. Frankowski** seconded. The motion carried unanimously with no abstentions.

Dr. Brown continued, stating that SPRS also recommended that if additional resources become available in the area of Youth Violence that applications addressing the effectiveness of housing voucher programs be given the highest priority, given the importance of, and great potential for, this innovative intervention. This focus also has priority in the Division of Violence Prevention. Therefore, SPRS recommends that if funding becomes available, the application "Long-Term Effects of Moving to Opportunity Experiment on Youth Violence" should be funded first. Other Youth Violence applications with priority scores of 250 or less should then be funded in rank order. SPRS recommends that if additional resources become available in other funding streams, the remaining applications should be funded in rank order.

Motion

Dr. Frankowski moved to approve the SPRS recommendations regarding funding for Youth Violence applications under Program Announcement 06004. **Dr. Li** seconded. The motion carried unanimously with no abstentions.

Program Announcement #06005:
Research Grants for the Care of the Acutely Injured

Drs. Denise Tate, Fowler, and Winston recused themselves.

Dr. Redfern reassumed the chair and said that under this Program Announcement, 38 applications were received. Two were deemed non-responsive. Of the 36 applications that were reviewed, 6 were streamlined, and 27 received scores better than 350. SPRS recommended that the three highest-ranked applications under the RFA receive funding. If additional funding becomes available, then the next funded application should be the fifth-ranked grant from Lerner, followed by applications scoring better than 250 in rank order. The rationale for recommending funding out of order was because the first, second, and fourth-ranked grants focus on psychological outcomes. The fifth-ranked grant, which concerns trauma field triage, should receive priority because the area of trauma field triage is important within the Division of Injury Response at NCIPC. With the input of expert panels, the Division worked to develop revised trauma field triage criteria. Mechanism of injury is an important step in those field triage criteria. Also, evaluation of any trauma field triage criteria is essential to assuring continual improvement in outcomes.

Motion

Mr. Reed moved to approve the SPRS recommendations regarding funding for Program Announcement 06005. **Dr. Li** seconded. The motion carried unanimously with no abstentions.

Research Cooperative Agreements

Dr. Redfern said that three Program Announcements were released under the Research Cooperative Agreements program. A total of 41 applications were received. Four were deemed non-responsive, 37 were reviewed, 6 were triaged, and 29 applications received scores better than 350.

Program Announcement #06006:
"Using Technology to Augment the Effectiveness of
Parenting Programs in the Prevention of Child Maltreatment"

Dr. Li recused himself.

Dr. Redfern reported that under this announcement, 24 applications were received. Three were non-responsive, 21 were reviewed, 5 were streamlined, and 6 scored better than 350. SPRS recommended that the applications with the three highest-ranked scores for this RFA be funded in rank order. Further, if additional resources become available, applications with priority scores of 250 or less will be funded in rank order.

Motion

Dr. Heron moved to approve the SPRS recommendations regarding funding for Program Announcement 06006. **Dr. Brown** seconded. The motion carried unanimously with no abstentions.

Dr. Li returned to the room.

Program Announcement #06007:
"Evaluation of Community-Based Approaches to Increasing
Seat Belt use Among Adolescent Drivers and Their Passengers"

No ACIPC members recused themselves from voting on this RFA.

Dr. Redfern said that seven applications were received, and one was non-responsive. Of the six that were reviewed, one was triaged, five were scored, and four received scores better than 350. SPRS recommended that the application with the highest score be funded. No proposals scored worse than 250.

Motion

Dr. Brown moved to approve the SPRS recommendations regarding funding for Program Announcement 06007. **Dr. Li** seconded. The motion carried unanimously with no abstentions.

Program Announcement #06008:
"Urban Partnership Academic Centers of Excellence (U-PACE)"

Drs. Tate and Winston recused themselves.

Dr. Redfern said that ten applications were received, and all ten were reviewed and scored. Nine of the applications received scores better than 350. This Announcement requires that one application from the Philadelphia area and one application from outside Philadelphia be funded. SPRS recommends that the Juarez application from Meharry Medical College in Nashville, Tennessee, be supported, as well as the application from Fein, in the Philadelphia area. If additional resources become available, applications with priority scores of 250 or less should be funded in rank order.

Motion

Dr. Brown moved to approve the SPRS recommendations regarding funding for Program Announcement 06008. **Dr. Heron** seconded. The motion carried unanimously with no abstentions.

Small Business Innovation Research Grants (SBIR) Phase One

Dr. Redfern said that11 proposals were received for Phase One projects. Eight were deemed non-competitive. Of the three that were scored, one was withdrawn, and two were not recommended. Therefore, SPRS did not recommend supporting Phase One applications in this funding round.

Motion

Dr. Brown moved to approve the SPRS recommendations regarding funding for Phase One of the Small Business Innovation Research Grants. **Dr. Li** seconded. The motion carried unanimously with no abstentions.

Small Business Innovation Research Grants (SBIR) Phase Two

Dr. Redfern said that two applications were received for Phase Two projects. One application was deemed non-competitive, one was scored, and one was recommended for funding.

Motion

Dr. Brown moved to approve the SPRS recommendations regarding funding for Phase Two of the Small Business Innovation Research Grants. **Dr. Li** seconded. The motion carried unanimously with no abstentions.

As there was no further discussion, **Dr. Fowler** thanked Dr. Redfern and SPRS for their hard work. With that, the session was adjourned.

General Session (Open to the Public)

Call to Order / Introductions / Approval of June 2005 Meeting Minutes

Dr. Carolyn Fowler
Johns Hopkins Bloomberg School of Public Health
Chair, Advisory Committee for Injury Prevention and Control (ACIPC)

Approval of June 2005 Meeting Minutes

Dr. Fowler called the forty-seventh meeting of the Advisory Committee for Injury Prevention and Control (ACIPC) to order at 1:45 p.m. She welcomed the group and noted that the November meeting of ACIPC had not occurred due to the effects of Hurricane Katrina. She directed their attention to the minutes from the June 2005 meeting of ACIPC and invited comments and suggestions regarding the minutes.

Motion

Dr. Heron moved to accept the minutes of the June 2005 ACIPC meeting. **Dr. Li** seconded. The motion carried unanimously with one abstention.

Discussion Points:

Introductions

Dr. Fowler opened the floor for public comment. Hearing none, she recognized the efforts of ACIPC members who have rotated off of the Committee:

- Dr. Leslie Beitsch
- Dr. John Corrigan
- Ms. Suzanne Brown-McBride
- Dr. Tom Cole
- Ms. Ann Menard

Dr. Wayne Meredith has resigned from ACIPC due to his commitments to other activities. Dr. Fowler thanked him and the members who had rotated off of the Committee for their contributions. She then asked new ACIPC members to introduce themselves:

- Dr. Nancy Guerra, University of California at Riverside
- Dr. Allen Heinemann, Northwestern University
- Ms. Diane Moyer, Pennsylvania Coalition Against Rape
- Dr. Denise Tate, University of Michigan
- Ms. Billie Weiss, University of California at Los Angeles

Dr. Fowler welcomed the new ACIPC members and asked the rest of the Committee to introduce themselves. CDC staff members also introduced themselves.

Executive Secretary Announcements

Ms. Louise Galaska
Deputy Director, National Center for Injury Prevention and Control (NCIPC)
Executive Secretary, Advisory Committee for Injury Prevention and Control (ACIPC)

Ms. Galaska greeted the group. After making housekeeping announcements, she directed their attention to the proposed dates for the next two ACIPC meetings. The tentative dates for the Fall meeting are November 15 – 16, 2006. The suggested Spring dates are May 15 – 16, 2007. She asked the group to note whether these dates conflict with a major event that might affect the committee members' ability to attend.

Agenda Review

Ms. Galaska described the rest of the meeting's agenda.

Ms. Andrea Hachat of Maximum Technology Corporation, Inc., described the reimbursement process.

Ms. Galaska introduced Ms. Amy Harris, the new Acting Director of Health Policy Analysis, and her staff Ms. Melissa Gipson and Ms. Yvonne Jennings. Ms. Harris will be the new Executive Secretary of ACIPC beginning with the November 2007 meeting.

Director's Update

Dr. Ileana Arias, Director
National Center for Injury Prevention and Control (NCIPC)

Dr. Ileana Arias said that CDC has developed new cross-agency goals to achieve greater health impact in the United States. As urgent threats and urgent realities take their toll, CDC must prioritize where its resources and attention are focused, especially during this time of tight budgets. CDC has identified four overarching goals:

- Healthy people in every stage of life
- Healthy people in healthy places
- People prepared for emerging threats
- Healthy people in a healthy world

Injury is a prominent health problem across the world and across life stages, and NCIPC is poised to focus its work to address CDC's goals. Like CDC, NCIPC is interested in focusing its attention and resources to best achieve greater health impact than would be achieved if they tried to address a number of issues simultaneously and in the same manner.
Therefore, NCIPC is considering how best to contribute to CDC's mission of addressing the health of Americans. NCIPC is combining goals related to infants, toddlers, and children by

adopting a focus on the prevention of ***child maltreatment***. This focus is important because of significant consequences to the physical and mental health of children and also because work in this area represents an investment in Americans' public health throughout all stages of life. NCIPC will contribute to CDC's efforts to protect older adults by focusing on the prevention of injuries related to ***falls among the elderly***. NCIPC can also contribute to CDC goals related to healthy places for Americans throughout the stages of life. CDC's goal in this area is divided into six subgroups, and NCIPC's focus lies in healthy homes as the Center addresses the ***prevention of injuries related to residential fires***.

These three high-priority areas for NCIPC emerged in the Fall of 2005 after a process of program review and priority-setting in which they focused on the goals and objectives that have the greatest impact on health. The process began with an internal exercise of evaluating the Center's program against important criteria:

- High-priority areas should have stakeholder support and ongoing complementary work.
- The issues should have demonstrable and measurable impact so the Center can document accelerated health impact.
- Areas of focus should have feasible interventions and address the burden of injury.
- All of the work implemented or supported by the Center should be evidence-based and aligned with CDC's goals.
- The work should be consistent with NCIPC's role within CDC and should be cross-cutting in order to have the greatest impact.

When the priorities were identified, NCIPC began to discuss how the Center could have significant effect in each of the areas. They focused on how the Injury Center functions and how it could function in the future to maximize its effectiveness and achieve its primary outcome: A reduction in morbidity, disability, mortality, and costs associated with injury. After identifying the outcomes, NCIPC identified its inputs, including infrastructure, human capital, and resources, and how those inputs could be used to accomplish the outcomes. The best way that NCIPC could further its goals is by implementing the public health model to address injury prevention in the United States. Activities in this area would include the development and maintenance of surveillance systems; research and development of programs; and engaging in widespread dissemination of programs after they are tested. There is a gap between identifying successful programs and the desired outcomes. Center staff are aware that they must share programs with their partner organizations and others who can implement them and accomplish policy changes. Further, external factors could change any aspects of the planning model.

This general framework will be applied to the specific areas of older adult falls prevention, residential fire prevention, and the prevention of child maltreatment. Such an exercise will identify the current status of the field, NCIPC's resources, and where NCIPC could focus to have maximum impact in each area. Draft planning models for each area have been generated. The Center will finalize their formats by the end of July, identify key stakeholders and partners for each area, and hold meetings throughout October to focus on the models and to determine whether the models capture what NCIPC should be doing as well as what other entities are doing so that all efforts can be supported.

The criteria that the Center used for evaluating its programs and identifying its priorities were not weighted as part of the analysis. Each of the priorities is important, and they are all slightly different. The Center has been involved in efforts toward prevention of injuries from residential fires. One program in particular has been shown to be extremely effective not only in preventing injuries from these fires, but in preventing the fires themselves. In this area, it was clear that NCIPC should expand its efforts to see that these programs are widely implemented. The Center has strong relationships with other groups that address residential fire prevention, so they are in place to have significant impact in this area.

The field has identified some programs to prevent falls among the elderly that are efficacious. Some programs have effectiveness data and some show promise. The Center hopes to take that information to the next level and starting implementing these programs widely in communities to see whether they will have impact.

Surprisingly, no intervention or program has been shown to be "the answer" for the prevention of child maltreatment. There has been agreement regarding the use of parenting programs or programs that address general parenting issues as well as more specific areas of child maltreatment. These programs have been effective in reducing the rate of child maltreatment, which includes physical abuse, sexual abuse, emotional neglect, medical neglect, and other kinds of neglect. Further, the programs are effective in other health areas. For example, children whose parents have participated in these programs are usually characterized by better physical health than children whose parents have not participated. Therefore, NCIPC intends to continue its investment in this area, which will have a significant impact on child maltreatment as well as on general child welfare. . The basic literature suggests that exposure to child maltreatment is associated with problems in childhood, such as injuries, and is also a risk factor for chronic diseases and mental health issues in adulthood. The Center frames its child maltreatment work in both contexts: protecting children and addressing risk factors for other conditions, such as obesity.

NCIPC is proud of a number of its accomplishments over the past year. Four achievements in particular are helping the Center to plan for the future. A notable accomplishment is the publishing of "The Incidence and Economic Burden of Injury in the United States" in April. This publication is a culmination of a three-year study to assess the national costs of injury in the United States in 2000. This study represents the most thorough examination of national costs in this area since the 1989 Congressional report on "Cost of Injury." The study had several co-authors from NCIPC, RTI, and the Pacific Institute for Research and Evaluation. It addresses the incidence of injury in the United States, the medical costs incurred as a result, productivity losses associated with the injuries, and total cost. The last chapter of the book compares the 2000 results to estimates from 1985 to discuss trends of injury and their implications.

In 2000, there were over 50 million medically-treated injuries. Nearly one out of five people in the United States experienced an injury that required medical attention. The lifetime costs of these injuries were $406 billion. Of that total, $80 billion is related to direct medical cost, and $326 billion is the result of productivity losses.
When assessing the costs of injuries across the lifespan, adults between 25 and 44 incur 40 percent of the burden and an over-representation of the costs associated with them. The study

also examined costs by mechanisms of injury, and motor vehicle crashes result in the highest total costs at about $89 billion, or 22 percent of the total economic burden. Falls are the next-highest injury on this list, with almost $81 billion, or 20 percent, of the total cost.

NCIPC has worked to organize the information in the book so that it is instructive and useful for individuals who aim to galvanize the public in addressing the importance of injury prevention. The study has limitations, but it includes the most complete injury estimates to date in the United States. The burden of injury is significant in this country, and it is hoped that the results of the study will be used by researchers, practitioners, and advocates to leverage resources for injury prevention. The Center is calling for more research on the development, evaluation, and dissemination of effective and cost-effective interventions to reduce economic burden. In their work, the Center encourages cost evaluation of interventions. The Center has engaged in wide dissemination of the information in the book, and additional activities are planned. A paper is due to come out in *Injury Prevention*, and a paper on costs of falls among the elderly is under review. Another effort involves the costs of self-inflicted violence and costs of TBI. The Center will identify other areas that can be addressed with the information and data that was collected in the study. Slides containing key points are available on the Center webpage. These slides can be downloaded for use in presentations or in written materials so that the information can be used for prevention education and activities.

The "Choose Respect" dating violence prevention initiative is important to NCIPC because of the great burden of dating violence in the United States. One in 11 high school students reports being the victim of physical dating victimization, according to the Youth Risk Behavior Surveillance (YRBS) Survey. About one in five high school students reports being the victim of emotional abuse, and one in five high school girls reports being physically or sexually abused by a dating partner. NCIPC has worked to advertise the availability of, and need for, Choose Respect. Recently-released YRBS data indicate significant risk factors correlate to victimization. Children who report being physically assaulted by an intimate partner were more likely to report that they had attempted suicide, engaged in binge drinking, engaged in physical fighting, and were sexually active, which increases the risk for early pregnancy and HIV and sexually transmitted diseases. Thus, a number of health effects are associated with dating violence, and the Center will address that spectrum.

Choose Respect is an initiative to raise the visibility of the problem of dating violence in the United States. It attempts to capture the attention of children before they are in danger of being a victim of dating violence or in danger of being a perpetrator of dating violence. The literature on dating violence and the communication literature led them to target Choose Respect to 11- to 14-year-old children. The campaign discusses healthy relationships rather than violence and focuses on maintaining healthy dating and non-dating relationships. If children and their parents and teachers are reached early with models of healthy relationships, there will not be as much room for violence in later relationships.

The campaign officially launched in May, taking the significant public health issue of dating abuse into communities across the nation. Throughout the summer, CDC is working, or has worked, with community organizations in:

- Washington, D.C.
- Hartford, Connecticut
- Houston, Texas
- Los Angeles, California
- Minneapolis, Minnesota
- Indianapolis, Indiana
- New York, New York
- San Antonio, Texas
- Phoenix, Arizona
- Topeka, Kansas

For this effort, CDC has partnered with the Women's National Basketball Association (WNBA), a group that has been traditionally interested in giving back to the community and to addressing health among girls. The WNBA has sponsored events in the above communities to highlight the problem and the availability of prevention materials. The Choose Respect materials are geared toward children, their parents, and educators. Parents are encouraged to be very involved with and to communicate with their children, not just in the area of dating violence. Tools are available to help parents. Tools are also available for individuals and communities interested in the initiative or in engaging prevention activities. The tools include video and audio Public Service Announcements (PSAs) that can be downloaded. Information is also available for children via a video game. In the game, the children create their own music video on the Internet. The video has nothing to do with violence or relationships, but in order to acquire the building blocks to the video, the children have to read information and answer questions about healthy relationships. Pilot testing showed the method to be successful in engaging children and in helping them to retain the material.

Prevention of injuries among the elderly is another priority area and a focus of future planning. NCIPC has invested in prevention of falls among the elderly in the past. Falls are the leading cause of injury deaths this American population. One out of three Americans aged 65 or over suffers a fall every year. Falls are also a leading cause of non-fatal injuries and hospital admissions for trauma. The most prevalent fall injuries are fractures, and the most serious and disabling fractures are hip fractures. 95 percent of hip fractures are caused by falls. Approximately 300,000 hip fractures occur each year among people over the age of 65. Half of older people who are hospitalized for hip fractures will not return home or live independently after the injury. The cost associated with falls is high. In 2000, almost $20 billion in medical care costs were attributed to fall-related injuries among older Americans.

Last year, NCIPC partnered with the CDC Foundation and the MetLife Foundation to produce and disseminate educational materials to help older adults prevent falls. Two CDC brochures, "*What Can You Do To Prevent Falls*?" and "*Check For Safety: Home Fall Prevention Checklist For Older Adults*," were upgraded, redesigned, and translated into Spanish and Chinese. The materials are designed for use by older Americans as well as their family members. "*Check For Safety*" is a 16-page booklet that helps people identify hazards and suggests solutions for them. "*What Can You Do To Prevent Falls*?" includes four key messages in brochures and posters:

- Begin a regular exercise program.
- Have a healthcare provider review your medicines to ensure that the combinations are not

contributing to drowsiness or dizziness.
- ❑ Have a vision check.
- ❑ Make your home safer.

These materials are available for downloading. NCIPC will engage in a national launch in September 2006. They will evaluate their efforts, and they plan to partner with a number of federal and non-federal partners for widespread dissemination of the materials.

The "Coaches' Toolkit" is designed to address the prevention of sports-related concussions, which are a significant problem among athletes. The Toolkit is used by coaches and trainers with high school athletes, who do not typically get the same attention that is afforded to athletes at the collegiate level. The "Heads Up Kit" includes information for coaches and parents as well as young athletes. The Toolkit was widely distributed in September of 2005. Approximately 30,000 Toolkits have been shared through partner organizations. Information is also available through the NCIPC website. To increase the visibility and availability of the Toolkit, NCIPC partnered with the Surgeon General in a series of radio tours to educate the public regarding concussions among young athletes and the availability of prevention measures. Evaluation information should be available at the next ACIPC meeting.

In closing, Dr. Arias said that NCIPC is generating good information regarding injury prevention. NCIPC hopes to identify good interventions and support their dissemination so their effectiveness in preventing injuries is maximized.

Group Discussion About Director's Update

Following a brief intermission**, Dr. Fowler** opened the floor for discussion regarding the Director's Update. She noted that the discussion was deliberately separated from Dr. Arias's report not only to give Committee members an opportunity to ask clarifying questions, but also to allow the group to consider the implications of NCIPC's prioritization in the field.

Dr. Cheryl Boyce asked about the Center's intentions regarding secondary prevention for child abuse. She noted that their activities had concentrated thus far on primary prevention and wondered about the possibility of secondary prevention tactics such as the identification of injuries in emergency rooms by physicians.

Dr. Arias replied that the Division of Violence Prevention's planning model for addressing child maltreatment centers focuses on primary prevention, but there is room to address secondary prevention. One of the Division's ongoing activities is the development of standard definitions for child maltreatment and data elements for surveillance. This work will address a secondary issue by identifying populations and risk factors, thereby leading to the development of secondary prevention programs.

Dr. Boyce asked about secondary prevention work to prevent falls among the elderly. NIH works on early assessment of cognitive disorders, providing one opportunity for preventing falls. **Dr. Arias** said that when staff discussed the Center's focus on fall prevention, they considered which populations should be the focus of their work, including whether they should concentrate

on higher-risk populations of persons with cognitive or physical disorders. For now, the Center has opted to "cast a wide net" in supporting programs that are at least efficacious, if not effective, in the 75-and-older population. Later, the Center can identify high-risk populations and target specific efforts toward those populations. To date, the Center has supported medication review work and has discussed the possibility of developing a guide for assessment among older Americans.

Dr. Fowler steered the discussion to address the "so what" question: what do NCIPC's priorities mean in the short and long term, and how can ACIPC help? She posed three questions to the group:

- Given that injury is such a resource-challenged field, and given that NCIPC has had to be creative in identifying certain areas to address with limited resources, what can ACIPC members do, either with NCIPC or within the field, to ensure that other injury priorities are also addressed in this country?

- Do we like the prioritization method? Do we have practical suggestions to offer as NCIPC sets future priorities? Other federal agencies and big organizations are also setting priorities at this time.

- What can ACIPC members do within their organizations to help NCIPC get buy-in for the priorities and proposed programs? How can ACIPC help the Center achieve the goals of spreading their message and integrating the messages and information within other priority areas in the country? The "Cost of Injury" report represents an opportunity to draw the nation's attention to injury.

Mr. Reed wondered about the Center's priority-setting process. He noted that ACIPC might be part of the process. He wondered about the consistency of the priorities with Congressional intents, the public interest, and other federal agencies.

Dr. Arias described the internal priority-setting process. Senior staff at the Center considered whether there was political will to support their issues. They agreed upon the criteria to be used and asked the Divisions to review their programs and name issues that were priorities for them, according to the criteria. Staff then took the high priorities of each Division, considered them as a Center, and applied the criteria to all of them. Of the nine priorities that emerged, three were selected. Their discussions were rooted in the Center's experience with partners and stakeholders as well as with Congress. There has been a great deal of recent interest in falls prevention, which included legislation for addressing prevention of falls among the elderly. The issue of residential fires has interest among federal and non-federal partners. Child maltreatment is an area that has political will, but more guidance is needed in framing the issue so that it is not threatening and will be supported. Some of the questions in this arena include whether to talk about child maltreatment in a general sense, or even not to talk about "child maltreatment," but to talk about "child welfare" or "child health." The Center has not discussed the priorities publicly, but they hope to create a plan to present for input no later than August.
Ms. Fingerhut noted that it is still difficult to collect baseline data on any of the three priority areas. Two national committee-level efforts are ongoing to improve external caused of injury

coding. The Council of State and Territorial Epidemiologists (CSTE) is facilitating monthly conference calls on this issue, and the Public Health Data Standards Consortium has a committee on improving external cause of injury coding as well. NCHS is staff to this organization.

Dr. Arias agreed, noting that the overall model as well as the individual models includes the development of surveillance systems. In addition to identifying and evaluating interventions that can be implemented and evaluated, the Center intends to create data systems to establish whether its efforts are having an impact. In the meantime, the Center ensures that all its supported work includes a strong outcome evaluation component so they can assess effects in controlled settings. It will be some time before the Center will be able to assert on a national level that its efforts are having that impact. They have to learn about the data systems that exist, the data systems that need to be developed, and the persons in position to get that information.

Ms. Diane Moyer was pleased to see that child maltreatment is a priority and agreed that it is difficult to talk about the issue. When Rape Crisis Centers conduct school programs, they focus on "healthy relationships," not sexual violence. She expressed interest in spreading "Choose Respect" in schools, and sexual violence advocates can partner with CDC to duplicate these programs. It is also important to engage emergency doctors and family physicians in recognizing injuries that are the result of abuse. She encouraged reaching out to the medical profession to identify this issue as priority for them as well. At the Pennsylvania Coalition Against Rape, they use CDs and a website, teenpcar.org, to reach teens in a comfortable and appealing way. She appreciated CDC's efforts in this area.

Ms. Weiss said that in their dissemination efforts, they must frame these issues so that they resonate with the public. Child maltreatment is perceived as a problem that applies to "other people." She concurred with the need for good baseline data to determine whether their efforts are effective. She advocated for data systems that gather information about child maltreatment, domestic violence, and sexual assault, especially given that a large proportion of these incidents are not reported.

Dr. Winston commented that mandatory reporting can be an obstacle to child maltreatment. In the domestic violence area, it is possible to report anonymously through new technologies. Reporting that pertains to children cannot be anonymous. She wondered whether they should lobby to create an atmosphere in which people who know that their children are at risk can feel comfortable reporting problems. There is a disincentive to discuss child maltreatment due to legal action, social isolation, and the involvement of the Department of Human Services.

Dr. Arias agreed, adding that the Center is interested in the primary prevention aspect of the work; however, this work is limited, as primary prevention activities do not always reach a large part of the burden. Particularly in child maltreatment, the Center is interested in addressing social, political, and individual will to address the issue. Before they consider the possibility of addressing the reporting laws, they will build their focus in child maltreatment to a "payoff" that will be valued.

Dr. Winston clarified that the laws should not be changed, but that people should be allowed to ask for help without resulting in a reporting situation.

Dr. Rodney Hammond said that they are not trying to change the laws. Their emphasis on primary prevention has advantages because some of their interventions are universal; that is, they can be applied to a population area irrespective of risk. For instance, they are examining strategies for primary prevention of abusive head trauma that can be implemented in healthcare settings. As part of these efforts, they will seek outcomes comparing locations where the efforts have and have not been applied. This approach avoids the issue of reporting, but the issue is valid. Public health has the advantage of working with practitioners that have a reporting role, but not an enforcement role. Families at risk can be addressed before they cross the threshold of "designated abuse."

Dr. Winston offered the example of the hotline numbers for Poison Control Centers, which people can call for anonymous information. It will be difficult to show effects if interventions are exercised with persons who are not likely to engage in abuse or other behaviors. To make a difference, interventions must reach a risky population.

Dr. Fowler applauded the child maltreatment priority, but she expressed concern regarding its potential negative connotations. She was further concerned with a "preoccupation" with child maltreatment, given the significant burden of unintentional injury in children. "Healthy people in healthy places" is one of CDC's goals, and she suggested framing the priority as "Healthy children in healthy places" so that children can grow and thrive without maltreatment or injury. The issue of child maltreatment has been linked to long-term negative consequences, but the risk factors are also risk factors for school failure, unintentional injury, and other problems. She wondered whether they should adopt an approach that is more socially acceptable and more apt to attract partners, such as "child wellness."

Dr. Heron concurred with this idea, noting that in her work with intimate partner violence, she brings messages to faith communities, schools, and neighborhoods where it is taboo to say "sexual assault" or "intimate partner violence." When she starts from a foundation of "healthy relationships," communities respond actively.

Dr. Fowler said that the literature shows that intensive home visiting is an effective means for addressing child maltreatment. These efforts are losing energy because of a lack of funding and because the public health nursing workforce is retiring, without new workers to take their places. This proven intervention might not be sustained.

Ms. Moyer cautioned against "not calling something what it is." While euphemisms can be necessary, changing social norms requires talking about difficult issues. If all of the issues are "palatable," then their importance might be lost.

Ms. Weiss agreed, but noted that buy-in from the public is important. Therefore, issues must be framed in a way that resonates with people who do not talk or think about them regularly.

Mr. Reed said the general public is beginning to talk about suicide, partially because suicide survivors who speak out have changed the field. Messaging from NCIPC could come from people who have lived through these experiences, who speak for themselves and help build

public awareness.

Ms. Lisa Dawson asked about other factors that helped them set their priorities.

Dr. Arias said stakeholder support was a major factor in their process. Staff members also hope to focus on areas with proven interventions and a high burden. The priorities should be in line with CDC's cross-cutting agency goals and in areas in which NCIPC and CDC have specific roles. They also focus on areas that are not only cross-cutting, but also far-reaching. For example, effective work in child maltreatment leads to other positive outcomes for children.

Ms. Dawson noted that these criteria will help to increase buy-in and also appeal to cross-cutting issues at the state level. CDC is good at helping to share consistent messages. Specifically, CDC has given public health professionals a consistent language to use when talking about HIV. In Georgia, 80 percent of the child fatality review cases are unintentional and a result of child abuse and neglect. When talking about child abuse and neglect, she has to talk about unsupervised unintentional injuries. The states could use guidance in better defining these relationships.

Dr. Arias remarked on the Center's work in standard definitions and data elements for the surveillance of child maltreatment. They have developed a broad definition of child maltreatment, and the issue of whether the case is "abuse" is left to criminal justice. Through the definitions, NCIPC hopes to capture cases of harm to a child, whether the harm is through physical, sexual, or emotional abuse; physical or emotional neglect; and unintentional issues. If there has been harm to a child, what produced the harm? Regarding communication, they will have to broadcast consistent messages not just about the priorities, but about injury in general in order to garner support.

Dr. Marsha Vanderford said that her group has reviewed injury prevention communication messages in the intervention literature to identify the most important communication objectives to advance the mission of NCIPC and the injury field. They have developed a model to look at those objectives and to identify where NCIPC stands relative to different injury issues. They anticipate convening a meeting of core partners in the Fall of 2006 to identify common objectives and to develop messages and materials to be shared.

Ms. Dawson shared that even people in the field are confused about the issues of child neglect. The issue of more severe neglect, such as leaving children unsupervised for many hours or all day, should be explored. In Georgia, the Child Endangerment Law is not utilized for unintentional acts such as leaving children in hot cars. Talking about these issues will lead to greater understanding of the consequences for harming children.

Dr. Fowler asked the group to respond to the general issue of prioritization. While NCIPC should have clearly-defined priorities, there are national ramifications to these priorities. Will the country see these priorities and think that they are the only issues that CDC finds relevant? Where do the research agenda and the acute care research agenda fit into the Center priorities?
Dr. Arias responded that at the Center, a "priority" area receives discretionary resources because of the promise of the impact it can have in the next three to four years. The Center has a number

of other important areas of concern, and that work is not ceasing. As soon as possible, NCIPC will articulate the activities that address the priority areas and then focus on other programs and how they can move to a priority level. For example, NCIPC has invested significantly in youth violence over the years. They need to identify champions in the area of youth violence prevention in order to get the sustainable support that is needed to implement programs that have been shown to be efficacious and/or effective. The Center must identify these champions so that the initiatives and efforts in youth violence prevention will get needed support.

Dr. Brown appreciated that the priorities will remain for three to four years, since it can be problematic to change priorities from year to year. He hoped that the criteria will last beyond three or four years. He asked whether the Center priorities align with federal priorities.

Dr. Arias replied that federal priorities are indirectly reflected in the Center priorities, since Center staff considered stakeholder support and whether a context existed for the work to "take hold." Because of available resources and the nature of the issues that are addressed, public health and CDC cannot do the work alone and must be cognizant of other efforts. Although there was not an explicit review of other efforts, the state of the field was strong in their minds when they discussed the priorities, and they will clear about their capabilities so they can collaborate with other agencies and programs.

Dr. Brown noted the importance of a champion and added that if an area were made a federal priority, then champions might naturally emerge.

Dr. Fowler thanked the group for their input and turned the discussion to the next agenda item.

Subcommittee / Workgroup Updates

SPRS: Report on Falls Research Portfolio and Evaluation

Dr. Mark Redfern
University of Pittsburgh
Chair, Science and Program Review Subcommittee (SPRS)

Dr. Redfern offered the group an update regarding SPRS, which has been involved in NCIPC's reviews of its research portfolios. They have completed a review of the Center's Violence portfolio, and they recently completed a review of the Falls portfolio. The goal of the process is to determine what CDC has done in the area in question, what has been effective, what has not been effective, and what can be learned as they assist CDC in setting priorities and informing the public.

The Falls Prevention Portfolio was led by Drs. David Sleet, Daphne Moffett, and Judy Stevens. The collected information was reviewed by an expert.

The goals of the review were to:

- Assess the focus, quality, and practice relevance of the research portfolio;
- Identify gaps and redundancies;
- Assess outcomes of the research; and
- Identify ideas for future directions.

Staff reviewed all of CDC's research in falls over the last 20 years. This work included intramural and extramural research across all mechanisms. The material was reviewed by a panel comprised of experts from varied backgrounds. A draft assessment of the research investment was created so that the panel could understand CDC's efforts and comment on them. The final report will be available within a few months. The report revealed a significant increase in death rates due to falls. Rates are still increasing, even when the statistics are age-adjusted. Further, men have a higher occurrence of falls than women.

CDC's research to address the problem of falls is in four categories:

- Define the problem
- Identify the risk factors
- Develop interventions
- Translate and disseminate the interventions

CDC's spans all four categories and certain "threads" are notable in the agency's long-term efforts. For instance, work began 15 years ago to examine the biomechanics of hip fracture. The work continued through designing hip pads to minimize the potential for fracture when a fall occurs. Those studies led to different methods in using, designing, and implementing hip pads. Further work considers barriers to using hip pads regularly. This portfolio review showed that CDC has contributed across the spectrum of the public health model.

The expert panel felt that CDC's surveillance systems provide key access data on fatal and non-fatal falls, which has made a significant impact on the field. CDC has also done important work in risk factors, such as the effects of long-acting antidepressants increasing the risk of falls and environmental factors in the home that can contribute to falls. Interventions have been done in case controlled studies. In the area of dissemination, NCIPC has created the National Resource Center for Safe Aging.

In its evaluation efforts, the expert panel employed a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis. The portfolio's strengths included the following:

- The projects were appropriate, mostly coordinated, and evenly distributed across the stages of the public health model;
- CDC's research portfolio in falls is well-respected internationally;
- CDC's work has provided a foundation for other studies;
- Research has been published in respected, peer-reviewed journals and has been widely distributed; and
- Projects demonstrating solid outputs and outcomes were included.

Some weaknesses and opportunities were identified by the expert panel, which included the following:

- There is a clear need for increased funding and resource allocation;
- Falls are the number one cause of injury, and yet research is lacking;
- There is a need for increased collaboration and expanded partnerships; and
- There is a need for improved tracking of projects and reporting requirements.

Many different agencies are involved in fall prevention and injury prevention in older adults. The importance of interacting with these different groups and engage in coordinated efforts was noted

The research portfolio report will yield products. An article, "NCIPC's Review of Falls Research" will be published, and the review has been invited for publication in the *Journal of Safety Research.* Staff will prepare the final report, explore methods to increase public attention to fall prevention, and seek resources to further address CDC's role in the prevention of falls.

Discussion Points:

Mr. Huber asked whether the review of 20 years of research revealed a specific strategy. He also asked whether clear success criteria exist for this area and whether the "failures" indicated by increases in fall injuries have been addressed.

Dr. Redfern replied in certain threads of research, it appeared that a strategy was consistently used. Work in hip pads, for example, showed a progression.

Dr. David Sleet noted that 17 to 24 staff members worked on the review at any given time. Regarding increases in injuries due to falls, similar trends are clear in other countries, particularly Finland, who are adopting aggressive steps to "neutralize that trend upward." This review represents the first time that many in the field have seen the trends between males and females. All along, NCIPC has used the public health model and therefore are now focusing more resources on interventions and dissemination of effective interventions.

Dr. Brown commented on the success and value of the review process. The process is also expensive in both staff time and funds. He suggested ensuring that they disseminate their work after the long process to get the most benefit from it. Peer-reviewed journals as well as other means of sharing information with the field will be useful. He further suggested learning about the process itself from the staff members who were involved and with the contractor that was hired. It is possible that structured abstracts could be an effective way to track projects in the future. A final report could include keywords and make the next reviews smoother.

Ms. Fingerhut asked whether the panel discussed a desire for more timely data.

Dr. Redfern did not recall a discussion regarding more timely data, but there was a call to consider coordinating different types of data across state, local, and national levels.

Dr. Daphne Moffett added that their discussions centered around driving their national-level data to other levels.

Dr. Frankowski reflected on the concept of "failing" in this area. If there has been a failing, then it is not on the part of the Center, but on the part of society not to invest the resources necessary to combat the problem. He found it remarkable that over 20 years, only an average of $1 million has been spent on a problem that accounts for nearly $100 billion in costs.

Discussion on Status of the Subcommittee for Intimate Partner Violence and Sexual Assault (SIPVSA) Subcommittee

Dr. Carolyn Fowler
Johns Hopkins Bloomberg School of Public Health
Chair, Advisory Committee for Injury Prevention and Control (ACIPC)

Dr. Fowler offered background regarding the subcommittee structure. The Subcommittee for Intimate Partner Violence and Sexual Assault (SIPVSA) was formed due to a feeling that this subject area has been "marginalized." Because of the charter under which ACIPC operates, a subcommittee requires administrative support. For instance, meetings must be announced in the *Federal Register* and cannot be held informally. Subcommittees are, therefore, expensive to run in terms both of time and of financial resources. This cost must be justified by the results of the subcommittee. At the last two ACIPC meetings, there has been agreement that SIPVSA has not produced a significant product. At the end of the June meeting, there was agreement from the members of the Subcommittee that it should be disbanded; however, there has been no official motion to conclude the work of SIPVSA. Ending this subcommittee does not mean that its issues are not part of ACIPC's work. Before tabling a motion to this effect, Dr. Fowler asked for comments and discussion from the group.

Discussion Points:

Ms. Moyer said that she was not aware of SIPVSA and what it was tasked to do; however, she wondered about how the issues of intimate partner violence and sexual assault, both major public health initiatives, fit into the work of NCIPC. She asked for more information about the subcommittee.

Dr. Fowler said that ACIPC maintains only two subcommittees: SPRS and SIPVSA. Discussions about SIPVSA have never concentrated on the value of work in intimate partner violence, but about how to justify investing that level of resource in a subcommittee that only addresses one area of injury.

Dr. Arias added the question of the best structure by which ACIPC can consider addressing issues of intimate partner violence and sexual violence. SIPVSA was challenging not only in resources, but in the direction, clarity, and focus of the group, versus using a workgroup structure to focus on particular issues.

Dr. Fowler thanked Ms. Suzanne Brown-McBride and Ms. Ann Menard, who have rotated off of ACIPC, for their outstanding work as part of SIPVSA. She also thanked Ms. Brown-McBride

and Ms. Menard for assuring that these efforts move forward in the best possible way.

Ms. Weiss asked whether a workgroup will be convened on these issues.

Dr. Fowler replied that a workgroup will not automatically be created, but that they could discuss the issue further.

Motion

Dr. Fowler tabled a motion to recognize the Subcommittee on Intimate Partner Violence and Sexual Assault for its work and its leadership, but to conclude the existence of the Subcommittee as a formal subcommittee of ACIPC. **Ms. Weiss** seconded. The motion carried unanimously.

Discussion on Status of Working Group on Injury Control and Infrastructure Enhancement (WGICIE) Workgroup

Dr. Carolyn Fowler
Johns Hopkins Bloomberg School of Public Health
Chair, Advisory Committee for Injury Prevention and Control (ACIPC)

Dr. Fowler explained that in 2003 and 2004, members of ACIPC formed the Working Group on Injury Control and Infrastructure Enhancement (WGICIE) to examine issues of injury control and infrastructure enhancement. The group also hoped to create a more precise definition of injury control and violence prevention infrastructure. The group presented a brief report on these topics to ACIPC on November 18, 2004. The report recommended holding a national strategic planning meeting to purse the issue of infrastructure development. At the time, NCIPC did not have the resources to host such a meeting. In addition, there was no agreement regarding the stakeholders that should be included at that meeting. No further action was taken, and ACIPC intended to pursue the discussion further at the November 2005 meeting, which did not take place.

Dr. Fowler noted that much has changed since WGICIE presented its report. She noted that the workgroup is no longer active. No progress has been made on the recommendations. The forum for ongoing discussion regarding these issues, the bi-annual National Injury Prevention Conference, will not be held in 2007 due to financial constraints. The release of the "Cost of Injury" report and the clear evidence of the burden of injury and the disconnect between infrastructure investment and burden represents an opportunity to bring these issues to light. Another opportunity comes from CDC's interest in cross-cutting programming and cross-cutting risk and protective factor investigation. Dr. Fowler asked ACIPC to consider "next steps" regarding infrastructure issues. They may not be ready to convene a workgroup, as they do not have a precise task for it; however, Dr. Fowler suggested that ACIPC devote a significant part of the November 2006 ACIPC agenda to a discussion of infrastructure, including an update of the current status of infrastructure and discussion and planning for "next steps."

Discussion Points:

Dr. Redfern felt that such a discussion would be beneficial, if it were productive. He suggested that ACIPC be given proposed structures for review before the meeting. The committee would then have a base for their discussion, rather than starting from "ground zero."

Dr. Fowler said that at the June 2005 meeting, Dr. Wayne Meredith suggested that they informally consider which stakeholders should be part of the discussion. She wondered whether they should begin those considerations now, or bring the process to the November agenda. The WGICIE report did not only address NCIPC infrastructure, but also federal, state, tribal, and local infrastructures. The report also addresses infrastructure for resources, career development, and building collaborative relationships for injury and violence prevention.

Ms. Amber Williams noted that the State and Territorial Injury Prevention Directors Association (STIPDA) will conduct a "round table" in this area within its cooperative agreement structure. They would welcome guidance regarding this activity.

Ms. Moyer asked for clarification regarding what ACIPC's discussions would address.

Dr. Fowler explained that WGICIE recommended that ACIPC address the issue that there is no significant infrastructure for injury and violence prevention in the United States. Although efforts to address these questions are supported by NCIPC and others, relative to the burden of injury in this country, there is little investment in infrastructure, including training, surveillance, personnel, career paths, and other issues. WGICIE ended because there was no funding to continue its efforts or to make its recommendations come to fruition. At the last meeting, the irony was noted that there was no infrastructure to support a workgroup on infrastructure. They need to create a strategy for the development of infrastructure to address injury and violence prevention in the United States.

Ms. Moyer wondered whether their discussion referred to each Department of Health's injury prevention branch or arm.

Dr. Fowler said that such organizations were mentioned in the report, but funding and training may not be present. The first block of inputs in the NCIPC logic model mentions human resources and capital, but the workforce is under-trained or un-trained in many areas, and many practitioners do not have an established career path.

Ms. Susan Hardman spoke from the perspective of injury prevention programs in local, state, and territorial health departments, which are in a "crisis mode." A recent sustainability report surveyed work at a number of state health departments revealed that all programs are different, but they are all struggling as funding is being cut. Their challenges are to sustain the workforce, empower the people who do work in the area, and link the work to researchers and career paths. If they do not dedicate time and resources now to consider infrastructure, then state and local health departments could cut their injury prevention efforts entirely. Injury Program Directors work to make their efforts recognized. When STIPDA created its cooperative agreements, they ensured that discussions regarding infrastructure would be a part of the process.
Regarding identifying stakeholders, they have discussed potential stakeholders and partners with the Society for Advancement of Violence and Injury Research (SAVIR). Their injury partners

are diverse, and they need to be educated regarding their role in the world of injury prevention. STIPDA would support an effort to create infrastructure on the part of NCIPC.

Dr. Stephen Hargarten commented that infrastructure is a huge challenge. Trauma surgery is undergoing a reexamination of their leadership and workforce as well. If there is no leadership at state or local health departments, then there will be challenges at trauma centers in years to come, because physicians do not see trauma as a career path. The Institute of Medicine (IOM) report will suggest that emergency departments are overcrowded and overwhelmed. Infrastructure is such a large subject, then it might be better considered in a broad way with a number of stakeholders to address it fundamentally.

Dr. Winston felt that ACIPC should consider its authority. It appears that the Center has decided how to spend its discretionary money, and infrastructure building is not part of the agenda. ACIPC can support the Center, but may not have an affect on its efforts. Good strategic planning includes decision-makers and specific time-phased work with specific questions posed to specific groups. Ultimately, the planners create a plan on which the larger group can vote. This approach is a good use of time. Many task forces have noted a need for infrastructure, but no progress is made toward creating it because decision-makers are not involved in the discussion. She offered the example of a group working on tasks for a period of time, discussing their progress regularly and creating new questions to address, and developing buy-in for possible scenarios to bring to ACIPC for reaction and guidance.

Dr. Fowler commented that the first two articles from the "Cost of Injury" book, which has been released since WGICIE shared its report, went to an injury prevention journal, which seemed like "preaching to the choir." She wondered whether they should pull strategic messages from the "Cost of Injury" report to aim at specific decision-makers.

Dr. Winston noted that materials should be shared, and she commended the Center for sharing slides on the website, but ways in which to use the materials must be made clear. Messages must be translated for specific audiences, material must be tailored for those audiences, and personnel must be trained in how to use the materials. This approach has led to 37 booster seat laws. She recommended rethinking how to spend discretionary funds to gain true value from the "Cost of Injury" report and reiterated the importance of changing the minds of decision-makers.

Dr. Arias recognized that messages must be tailored. The Center has identified priority topics within injury that can be addressed and will be supported. There is difficulty in selling "injury prevention," as it means different things to different people, which can lead to it meaning nothing to everybody. Similar struggles have emerged when they have addressed the issue of infrastructure. She wondered about an alternative to addressing "infrastructure" for injury prevention, whether in the context of the priority areas or in other topics that can be addressed in a cross-cutting way and built upon to address infrastructure at a broader level. She was concerned that they would be limited both internally and outside CDC in generating excitement about improving the infrastructure of injury prevention. Instead, they could adopt the approach that, for instance, youth violence prevention specialists must be trained because youth are dying as a result of violence. This message will reach people who are interested in youth violence, and it addresses issues that are important to them. They must address infrastructure issues

specifically in order to get support.

Dr. Hargarten said that certain models are investing in future scientists and future leadership. NIH has been working in this area for some time, and there are opportunities to develop model collaborations for training in the elder population for falls prevention. The National Institute of Aging (NIA) has a training program and opportunities for collaboration that could be models for infrastructure to invest in a spectrum of professionals. Fogarty is investing in training in international health, collecting funds from multiple Institutes across NIH. Federal agencies can collaborate on model investments to address the priorities that are focused, address a major burden, and that have growth potential. With this approach, it might be possible to present strategic inter-agency planning strategies to ACIPC in November.

Dr. Winston agreed, adding that if a strategic plan for infrastructure is created, then they can build the tactics to operationalize the plan. Their work in the three priority areas can feed into fulfilling the goals of the strategic plan, rather than working in a "piecemeal" approach that does not take the Center's future direction into account.

Dr. Arias agreed, noting that NCIPC hopes to avoid the "piecemeal" approach. Resources are limited, but they can be used better. They have not yet identified short- and long-term activities for the priorities. They need to consider how to "make things happen." For example, regarding implementation, is working through their core state programs the best venue? They need to identify means with a minimum of infrastructure, but in some cases, they will have to create infrastructure.

Dr. Winston said that regardless of the current state of resources, there should be a long-term plan for addressing the burden of injury. In the meantime, relatively small activities are "pieces of the plan" rather than ends in and of themselves. For example, in child maltreatment, structures could be put in place to address both child maltreatment and unintentional injury. Their work can incorporate the overall vision.

Dr. Fowler asked whether the group wanted to recommend a "next step." This issue is complicated, and it is difficult to conceive of a starting action that is discrete, defined, and within the purview of NCIPC.

Dr. Hargarten suggested that they outline the prevention, acute care, rehabilitation, workforce, and structural needs to implement the three priorities. They could conduct discussions to examine gaps, shortfalls, and challenges in the context of the priorities and their burden.

Dr. Fowler asked whether ACIPC was the appropriate vehicle for this work, or whether ACIPC should function as a means to create a broader national dialogue or strategic meeting.

Dr. Hargarten endorsed the idea of a strategic meeting. Such a meeting is crucial because a great deal of work is being done all over the country, but the work is fragmented. The three priority areas can highlight the challenges and fragmentation among federal agencies, state agencies, and the number of other groups that work on these issues.

Ms. Weiss agreed, noting that the three priority areas lend themselves to involving federal partners. As a start, each state ought to have a trained workforce in injury prevention. In California, personnel are leaving and not being replaced, and the infrastructure is weakening.

Dr. Redfern said that it might not be feasible to create a plan for infrastructure for feedback. He suggested that they create a process by which a plan can be developed.

Mr. Reed pointed out that the priorities of falls among the elderly and child maltreatment reach beyond the injury prevention community, especially when considering the consequences of not dealing with them. Discussions about infrastructure should not be limited to injury. He recommended that they analyze each priority to assess which groups, agencies, and issues the priorities touch. Those resources in other fields could be part of the infrastructure. For instance, a risk factor for elder adult suicide is falls and fractures. This connection is an opportunity to connect the fields of injury and suicide.

Dr. Fowler asked if any members would be willing and interested to participate in planning for a facilitated discussion in November.

Dr. Redfern noted that they should be sure that the appropriate people conduct this work.

Dr. Fowler suggested that they consider the feasibility of having a facilitated priority-setting discussion for process development at the November ACIPC meeting. They need a clear understanding of the process that they will use to think about the needs of the three priority areas.

Dr. Redfern suggested that a proposed process be presented at the meeting so that the committee can react to it.

Dr. Fowler said that the WGICIE could be reconvened as an ad hoc process exploration group with a defined task and timeline.

Ms. Galaska commented that this task is an appropriate use of a workgroup.

Dr. Fowler asked whether an ACIPC workgroup could include input from other partners who are not members of ACIPC.

Ms. Galaska replied that the workgroup should have one or two ACIPC members, but anyone can participate.

Ms. Weiss suggested that they include partners who might help in the development of an infrastructure for injury.

Dr. Fowler proposed convening an ad hoc workgroup to move the issue of process to identify prioritized infrastructure needs forward.

Ms. Weiss added that the group should discuss methods to get to the plan.

Dr. Redfern clarified that the group's goal would be to have a proposed process in place for debate at the November ACIPC meeting.

Motion

Dr. Fowler proposed that ACIPC convene an ad hoc working group to create a draft process for developing prioritized infrastructural needs by the November 2006 meeting. **Ms. Weiss** seconded. The motion carried unanimously.

Preview to Wednesday's Activities

Dr. Ileana Arias, Director
National Center for Injury Prevention and Control (NCIPC)

Dr. Arias said that the Injury Center's research agenda is the result of a process that was initiated in 2000. There was extensive input into the development of the agenda from both governmental and non-governmental groups. In this process, criteria were used in two ways: to determine the content of the agenda, and to determine the agenda's priorities. The Center did not limit areas that would be supported, but rather highlighted areas of particular interest.

The criteria for the themes and recommendations in the agenda include the following:

- Are the elements consistent with the mission of CDC and the mission of the Injury Center?
- What is the public health burden associated with the issues?
- Is there a research opportunity in these areas?

The agenda was published in 2002 and has been used to guide NCIPC's investments in intramural and extramural research. It is intended to serve as a guide for five years, Five years may not be long enough to evaluate progress. In May, an addendum focusing on acute injury care was added to the agenda. The agenda is intended to be part of CDC's agency-wide Research Guide, which will be released later this year.

The agenda guides the research program at the Center. Focus on effectiveness and efficacy studies is critical in each chapter of the agenda. Further, research to address the appropriate and effective dissemination of the programs is an area of concentration. Over time, there has been an increase in support for research focusing on the topics in the agenda.

The Center is considering updating the agenda. Among the issues in their work is the extent to which information from their portfolio reviews will be incorporated into the updating process, and the role that the reviews will have in the evaluation process of the overall agenda. They are also considering the agenda's relationship to priorities identified in CDC's Research Guide and their relationship to CDC goals and organization.

Each topic in the research agenda includes a number of themes. Frequently, resources are only available to fund a limited number of grants in each area. Therefore, they are limited in advancing their goals of addressing the themes in the agenda. The Center is considering whether to continue the research agenda as it has in the past; that is, all topics in the agenda are appropriate for RFAs. This approach means that funded researchers are qualified to address the issues. However, this approach can lead to an uncoordinated response and can limit the quality and strength of the evidence that is accumulated over time. Their alternative is to set priorities to limit their focus.

The Center is considering embarking on priority-setting process for the research agenda, not to exclude themes, but to focus the investment of extramural funding on one or two key issues over a period of three or four years to ensure that a critical mass of information can be gathered and acted upon. If that approach is preferable, then they have to decide on a process for narrowing the themes for focus, including the criteria that should be used. Some of their criteria for identifying priorities for the Center will be applicable, but other issues should be taken into account as well, such as the relationship between the priorities in the research agenda and the global priorities that have been set for the Center. Further, they should consider the relationship by those priorities and the priorities that CDC will create for implementing the Research Guide.

Dr. Arias asked that ACIPC members prepare to have a discussion regarding the merits of focusing the research agenda versus not focusing it. If there is merit in focusing the agenda, how should the decisions be made? How should they identify the topics that will be areas of focus for

a time? How many studies are critical; for instance, how many effectiveness studies should be conducted on a particular topic before the issue can be acted upon? She noted that copies of the research agenda were available.

With that, **Dr. Fowler** thanked the group for their energy and participation. The meeting was adjourned for the day.

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Wednesday, June 14

General Session (Open to the Public)

Announcements from ACIPC

Ms. Amy Harris, Acting Director of Health Policy Analysis
National Center for Injury Prevention and Control (NCIPC)
Centers for Disease Control and prevention (CDC)

Ms. Harris drew the group's attention to copies of handouts that some of them might not have received. She offered to share any other materials with them. Following the meeting, a CD-ROM will be sent out with all of the referenced materials and the notes from the meeting.

She described another handout, the "Funding History Graph." Between FY 2005 and FY 2006, there was a small increase of just under $1 million in the injury appropriation. In FY 2005, the funding level was $138.2 million, and in FY 2006, the funding was $139 million. In the President's budget for FY 2007, the appropriation went down slightly. The proposed funding level for injury is $138.2 million, the FY 2005 enacted level. The House Subcommittee and full committee markup have occurred, and the House recommends a funding level of $138.6 million. This amount is still $.5 million under the 2006 enacted level, but it is better than the original proposal. Injury has fared well, compared to other areas of CDC and given the current environment. The next step in the process will be a House vote, and then the Senate will undergo the same process.

Discussion Points:

Dr. Brown asked about the implications of the budget and whether it would be possible that CDC would not have a research budget.

Ms. Harris replied that if a bill is not created, then a Continuing Resolution (CR) will be issued. CRs typically fund at the preceding fiscal year's funding level.

Dr. Brown asked if CDC operates under a CR, whether the RFAs will still go forward.
Ms. Harris replied that they would.

Dr. Fowler noted that NCIPC is in a fairly good position, but many state and local programs are funded through block grants. She asked whether any staff members had done calculations of the potential impact of those cuts on injury.

Ms. Harris answered that the House restored the block grant program at $100 million, even though the President's budget proposed its elimination.

Ms. Lois Fingerhut
National Center for Health Statistics (NCHS)

Ms. Fingerhut invited the group to the National Center for Health Statistics (NCHS) bi-annual Data Users' Conference on July 10 through 12. The conference is free and addresses the data systems at NCHS and includes hands-on exhibits, websites, and workshops.

Dr. Fowler asked Ms. Fingerhut to share this information with Ms. Amber Williams, and for Ms. Williams to share with state health departments through STIPDA.

Group Discussion

Ms. Louise Galaska, Deputy Director
National Center for Injury Prevention and Control (NCIPC)
Executive Secretary, Advisory Committee for Injury Prevention and Control (ACIPC)

Ms. Galaska introduced the morning's charge, which was to discuss how to manage NCIPC's Injury Research Agenda in light of the current environment. She recalled Dr. Arias's update on CDC's goal process and how NCIPC has created its own program priorities to focus its resources on injury areas that can have quick health impact. She reminded the group of the three priority areas:

- Reducing or eliminating injuries from older adult falls
- Reducing or eliminating injuries and deaths from residential fires
- Reducing or eliminating injuries from child maltreatment

NCIPC uses a logic model so that its energies and resources support the three priority areas in achieving health impact. The funding for NCIPC in 2007 will not provide sufficient resources to accomplish all that they would hope across the spectrum of injury prevention and control. She asked that ACIPC provide suggestions regarding how to take the next step in focusing resources. This approach is an efficient way to operate and realizes that the resources are not available to do all the work that they would like to do. NCIPC needs ACIPC's input in several areas:

- Should NCIPC limit or focus its research investment to one or two key issues within a topic to get a critical mass over three to five years?

The Research Agenda is broad and structured to cover different areas of injury prevention and control. Within those areas, different approaches can be taken to the research to move the areas forward. In the past, although there was some focus in the research agenda, many areas were funded. NCIPC might need to focus its research agenda in a more structured way in order to yield research findings that can be built on to support interventions, programs, and more immediate health impact.

- If NCIPC needs to focus its investment, then what are the potential challenges? What criteria should be used for the focusing?

She recalled that when developing the Injury Research Agenda, they used three criteria: 1) Whether the topic aligned with CDC's mission and NCIPC's mission; 2) whether the topic was a significant public health burden; and 3) whether the Center could add to the field research in the area.

Discussion Points:

Dr. Tate asked how the Center's priorities related to the acute injury research agenda.
Ms. Galaska replied that the three program priorities are areas of injury prevention and control in which the Center has worked for several years. Research topics in the agenda relate to achieving the goals in falls among the elderly, child maltreatment, and residential fires.

Mr. Reed asked whether their discussion should center on research regarding the three program priorities, or whether they should include any research priority in the agenda. **Ms. Galaska** answered that their discussion should start with a broad view.

Dr. Guerra said that the Center has to focus its investment in a manner that is fair and that reflects input from a variety of constituents as well as the funding mechanism. For example, the violence research portfolio is complete. Different federal agencies are involved in the field, and the different efforts do not always communicate with each other. A first step could be to set research priorities within each area. Youth violence has to be a priority because of its funding level, even though it is not one of the three top priorities. She suggested meeting with researchers from other agencies who work in a given area to determine the priorities of the kinds of studies that are needed. This process requires discussion and could include public input. Some areas are clearly wise for investment. For example, among the Academic Centers of Excellence (ACE), it has been discovered that no good self-report of violence addresses victimization and types of violence. Work in this area would advance the field. Once the priority areas in each segment of the field are agreed upon, then they must be used. She advocated for not issuing a very specific RFA, but rather stating that preference will be given to applications that address the stated priorities. It might also be helpful if review committees were made aware of the priority areas and scored the applications according to where they fit into the "bigger picture." Secondary review could then consider programmatic balance more clearly. Many funded programs seem to be redundant, and a means for prioritizing the grants and a

mechanism to share those priorities could alleviate those problems. Finally, it would be helpful for researchers who operate under different agencies to meet and discuss their efforts.

Dr. Iris Mabry-Hernandez agreed that the Center's investment should be focused. Public and stakeholder input will be important. The U.S. Preventive Services Task Force published a notice in the *Federal Register* which included not only specific criteria about the topic, but also explained why the issue is important and where the research stands. This approach could collect external input regarding important areas in injury prevention. In addition to considering CDC's mission, the main points in the current administration's "500 Days" and the mission of the Department of Health Human Services could be taken into account.

Dr. Heinemann suggested that opportunities for translation or dissemination could be criteria to consider to "get more bang for the buck," for example, if work could translate across populations.

Ms. Galaska asked how to measure these opportunities. **Dr. Heinemann** posited that internal consensus as well as cross-agency discussions could be helpful.

Dr. Hargarten recalled a shift in supported research toward the third and fourth steps of the public health model. He observed that if dissemination and the development and testing of interventions are special foci, then this approach is consistent with NIH, which is moving toward translational research in both a clinical context and in community research. Priority could be given to research efforts that address the third and fourth steps. There is a great deal of activity going on at NIH, and NCIPC could balance with NIH's efforts.

Dr. Fowler agreed that NCIPC cannot and should not address every aspect of injury. At the same time, CDC is the lead federal agency for injury prevention and control. If NCIPC is not watching out for the entire field, then no entity would be. It is reasonable to assume that other agencies are funding research in injury prevention and control, but if NCIPC excludes certain areas because of a narrowed focus, then it cannot be assumed that other funders will support the "gaps." For this reason, any move toward prioritization must include discussions with other major funders in the field to ensure that there is funding across the data-driven priority areas. If NCIPC will focus its research funding, then she encouraged the Center to consider "seed funding" to promote the beginnings of other work, especially given that researchers are not eligible for NIH funding without some baseline work.

Mr. Reed felt that the criteria should include the nation's view of public health threats. For example, "cutting" and self-injury is a significant problem, and no large efforts are focused on the impact of these behaviors on young people. Further, certain dimensions of suicide, such as the mental health component, are not being investigated. Public and Congressional perception should be assessed so that the Center can potentially use the concept of "seed funding" to advance research to demonstrate the public health role in injuries.

Dr. Mabry-Hernandez asked for an explanation of the Center's funding mechanisms. For instance, AHRQ has priorities, but investigators can submit their own proposals. **Dr. Arias** replied that CDC's system is similar, with some restraints. Some of the monies that CDC receives are identified for specific areas. Center staff work internally and with outside experts to determine areas that have research needs and to target RFAs to those themes.

Dr. Frankowski asked whether NCIPC has set qualitative or quantitative goals for the priority areas. These goals might help to focus the research areas. **Dr. Arias** answered that goals have been set for fires and for falls, and they are essentially mortality targets. NCIPC is not at a stage where they can set goals for child maltreatment, as there are no reliable systems in this area. The implication, therefore, is that research is necessary to develop those systems, whether they rely on self-report or another means for detecting mortality and morbidity rates.

Dr. Guerra advocated for balancing responsiveness to public concern and crafting a strategic research agenda. Within the areas that have already been designated, they could create a mechanism for assessing gaps and adopting a more narrow focus. At the same time, CDC should respond to public issues such as "cutting." As CDC has responded to concerns regarding avian flu, she wondered if there was a way to create "rapid response" funding for innovative programs to address clear, emerging public health problems.

Dr. Fowler acknowledged the importance of considering public concern because it represents stakeholder support, but she was concerned that issues discussed by the public and on television are not always supported by data. The media over-concentrates on focused areas of injury, where other problems that kill many more people are overlooked. When they think about public concern, they should specify which public they mean: the informed public, or the uninformed public. Focusing NCIPC's work is an opportunity to do good work in a few areas, but may miss thousands of other injuries. Intentional injury is under-funded, but has more support than unintentional injury, partially because the public is aware of intentional injury.

Ms. Weiss said that having three priorities provides an opportunity to examine real issues that may not have been fully investigated, such as mild traumatic brain injury (TBI). The priority of falls among the elderly encompasses concerns regarding the aging population. Public perception can be misleading, and research is needed in areas that cause a great number of injuries. Focusing on three priority areas means that they will be able to increase their body of knowledge to design interventions and preventions that work.

Ms. Galaska clarified that Ms. Weiss was suggesting focusing not only on the three program priority areas, but giving preference within those priorities to research proposals that meet a cross-cutting need, such as interventions in child maltreatment that will have comprehensive impacts on child, adolescent, and adult health. **Ms. Weiss** agreed, noting that these impacts can particularly be observed in mild TBI, about which little is known across the lifespan.

Dr. Brown added that the issue of child maltreatment is larger than any single institute can tackle. Work in this area requires advance discussions and agreements with other agencies to do co-funding as opposed to the traditional method of "borrowing money" from another institute. This communication should occur at the Director level. He further recommended finalizing a

means by which the peer-reviewed applications in injury prevention could be eligible for funding through NIH, which will include inviting Project Officers to the reviews. It may be possible to enlist a chair from an NIH peer review committee to serve on a CDC peer review committee. Further, he recommended clearly declaring that NCIPC would focus on the three priority areas and would solicit collaborations from other agencies. Building a base for people who are thinking about joining the field is a worthwhile task. He suggested working with students who are studying public health and preventive medicine. Public health schools are moving toward licensing for their Masters programs in public health. If some of the tests included questions on injury prevention, especially in the three priority areas, then the interest in these issues can begin during future practitioners' schooling.

Ms. Galaska suggested that the group focus the discussion first on criteria, then on process. If the Center opts to focus its research on the three priorities, then there must be a means for deciding the research that should be funded within those areas. In the past, the Center has attempted to look at funding in a three- to five-year span; that is, aiming research at longer-term projects rather than adopting a "scattershot" funding approach that changes yearly and that does not facilitate follow-up. There has been some success in building on research.. The field includes a great many ideas and a great many areas that need research, and NCIPC should avoid supporting research that does not build and does not result in health impact.

Mr. Huber commented on the falls prevention research portfolio and NCIPC's mission. A mission to be "vertically integrated" and to see research through to its impact might result in a small number of initiatives being supported. If the mission relates to the public's perception and the reality of the injury problem, then it could include sparking public awareness. The research could highlight needs and issues in general injury and bring them to the public's attention so that other groups will pick up on the issues. They should find the "gaps" and close them, especially since they do not have the funding to "vertically integrate" their work.

Dr. Guerra observed that the Center needed a specified process to set the criteria, rather than working in an ad hoc fashion. She recommended creating a process for defining the mission, fitting the priorities within the mission and within the three program priorities, and including federal partners to discuss their funding and co-funding priorities. With this structure, NCIPC could discuss gaps and how to balance public interest in their efforts.

Dr. Fowler said that the decision about criteria depends on the overall approach to research. If the Center elects to pursue a "vertical integration" model, then the criteria will be different from a model that includes partnerships with various agencies to address pieces of the issues that lie within each agency's mission and expertise.

Dr. Frankowski suggested convening a special committee of national and international experts in each priority area plus grantees. This group could help the Center refine where work is being conducted, the gaps in research, and create specific and achievable priorities.

Ms. Galaska observed the important suggestion to collaborate with other organizations and agencies to ensure that the overall research agenda is comprehensive. She said that the research agenda was assembled five years ago with the assistance of other agencies and experts, so

another effort to come together might not result in new conclusions.

Dr. Arias concurred, adding that the Center solicited input via an announcement in the Federal Register. She said that the Center is creating a system to review the research agenda. The group that will evaluate the Center's work in response to the agenda and make recommendations for changes in its content and implementation could be charged with creating a process for prioritizing topics across the agenda or within each of the agenda's themes.

Dr. Heron noted that substantial resources were invested in evaluating the falls research portfolio, and the work included expertise from the United States and internationally. With that baseline, they should ensure that a substantive outcome results from the review and that the information is shared. CDC's work in falls prevention spans 20 years, and so it may not be possible to show significant results in two or three years. She cautioned the group to "use what we have" and how to maximize their knowledge and experience.

Dr. Guerra said that their plans tend to be broad, and the next steps include becoming more specific, particularly regarding the work that fits within CDC's mandate. For example, good data is not available regarding "cutting." As CDC excels in surveillance, CDC is more appropriate to conduct this work as opposed to NIH.

Ms. Galaska said that if NCIPC re-evaluates the research agenda with the help of others in the field, they still need criteria to identify which activities should be funded. The research agenda is large and a large number of research topics are available, even within the three priority areas. Preference or priority should be given to some of these topics. They had a set of criteria when the research agenda was created and another set of criteria for identifying programs. These criteria were used in an informally weighted way to lead the Center toward programs that can be implemented. In this vein, discrete criteria are needed to choose priority areas for funding. For instance, they may want to consider whether the areas fit within the Secretary of Health and Human Services' "500-day plan" or which types of research will be supported by stakeholders. These external factors must be considered along with internal factors such as the state of the field in a program area. Some areas need a small "push" to be ready for implementation, where others are farther to the left of the public health model and need a great deal of time and funding to be able to be implemented. In their planning, they must weigh the need to show immediate impact in an area that might be less of an overall burden versus the need to focus work on critical areas with significant burdens that might not have readily available interventions.

Dr. Brown observed that the process by which the three priority areas were identified was successful. He has noticed enthusiasm for this difficult process and acknowledged the leadership and staff of NCIPC that went through it. In order to be selected as a priority area, a topic needed to "score" high in each criterion. The research agenda, which uses the public health model, requires more balance and is not well-suited to a "scoring" system. He suggested weighing the parameters to ensure this balance.

Dr. Tate said that the criteria should reflect the needs of the field and the impact of the work. The criteria will show areas of greatest benefit, and how they relate to the stakeholders. The views of the stakeholders will be subjective, but the criteria must be chosen objectively. NCIPC

has already experienced the process and has done some of the "legwork." A separate issue is feasibility of implementing the goals and ensuring that they are consistent with NCIPC's mission and CDC's mission. After identifying the process, then it will be important to determine other agencies' efforts in the areas and collaborating with them.

Dr. Boyce said that co-funding has been explored in the area of suicide. CDC went through the Center for Scientific Review at NIH. A Scientific Review Administrator from NIH would have to be present at the review. With sufficient advance warning, it will be possible to work together, even though the mechanisms for receiving grant applications are different. Through setting agendas, NIH learned some lessons. One lesson is the importance of the marketability of the research agenda. The "Road Map" gained momentum and had general support as a means for refocusing the Centers' work. Some of the "Road Map" issues might be relevant to CDC. Further, the Office of Behavior and Social Sciences Research is about to celebrate its tenth anniversary and used this event to incorporate technology into setting its research agenda. This structured approach was more cost-effective than convening a number of meetings and revealed new ideas and questions. The software was generated from a government contractor, NCI, and was low-cost. The "grants.gov" initiative may make it easier for all agencies to meet goals.

Dr. Redfern observed that setting criteria is a staged process. They must be aware of other efforts in the field, assess potential areas for collaboration, and determine the work that will have to be done by CDC alone.

Ms. Galaska said that the comments were all helpful, and she noted the emergence of "fundamental guiding principles," or groundwork, that is needed before setting the criteria.

Mr. Reed said that good data does not exist for some of these problems, and CDC must fill those gaps. They should target RFAs to the public health issues of their three priorities, emphasizing cross-cutting relationships within the research agenda. The research could lead to increased funding. Research should inform knowledge about these areas so that policies and resources, whether federal or foundation, can follow. He encouraged NCIPC to release one RFA to cover other projects and programs in the research agenda. Focusing on three priorities may send a message to the field that NCIPC does not care about the other areas. An additional RFA for innovative research in the other areas may stimulate a new idea.

Ms. Galaska wondered about other impacts and implications that may come from prioritization. What should NCIPC be prepared for, and what is the Center sacrificing?

Dr. Fowler supported the research focus and felt that it is appropriate to use different criteria for prioritizing research and programs. Ultimately, long-term research should enable the field to create and implement good programs that reduce the burden of injury. If certain areas receive more focus, then the other areas may become less feasible, there may be less support for research in that area, and there may be less stakeholder support.

Ms. Galaska agreed, noting that the current environment expects "quick wins" and immediate impact, which is not unreasonable. At the same time, they have to remember the comprehensive needs of the field for years to come.

Dr. Hargarten compared their efforts to managing a money market fund, which has interests in short- and long-term gains, focus areas for investment, and a need to "get the biggest bang" for the investments. NIH's shift to the "Road Map" has led to their move toward translational research. NCIPC has engaged in good, rigorous, and productive activities. They should balance their short-term gains with longer-term work, perhaps by focusing on interventions and dissemination while asking partners to engage in foundational work. At the same time, the research portfolio shows a robust "seed project" mechanism to encourage ideas with cross-cutting implications. Investing in researchers is important in injury and can cut across federal agencies such as the Consumer Products Safety Commission, the National Institute of Justice (NIJ), the Department of Justice, the Department of Transportation, NIH, AHRQ, HRSA, and the Department of Defense (DOD) through its research arm, the Defense Advanced Research Projects Agency (DARPA). ACIPC could play a leadership role in gathering these agencies. **Dr. Redfern** clarified that DARPA translates information that has been developed by the military into the private sector.

Dr. Arias emphasized that NCIPC's research does not have to be limited to the three priority areas. Staff chose the three areas partly because research has been done in the areas to guide implementation efforts. It could be beneficial to use the research agenda to integrate the activities of priority-setting for program and for research. The Center's plan includes building up the other research areas so that they become priority areas in the future. Stakeholder support and research will elevate the topics.

Ms. Moyer supported the idea of being able to respond to emerging issues. In this climate, the continuity of the Center requires demonstrating how its efforts impact lives, save lives, and alter behavior in the United States. The possibility of future research projects relies on proven outcomes, which can be shared with Congress and decision-makers.

Resume Discussions

Ms. Louise Galaska
Deputy Director, National Center for Injury Prevention and Control (NCIPC)
Executive Secretary, Advisory Committee for Injury Prevention and Control (ACIPC)

Ms. Galaska synthesized the morning's discussion, which she stressed had been important because staff will be able to develop a comprehensive foundation for their efforts in prioritization. They have agreed to focus their research within the priority areas, and ACIPC has provided recommendations and advice regarding how to focus effectively. She asked the group to reflect on the implications of focusing their research dollars, such as possible negative perceptions in the field:

- What should NCIPC anticipate?
- What can they prevent?
- What needs to be addressed or mitigated?

Discussion Points:

In her experience as a project officer for pediatric grants at AHRQ, **Dr. Mabry-Hernandez** has observed that researchers may feel that submitting an application is not worth their time, given the lack of resources and the narrowing of research focus. At AHRQ, they are clear about their focus areas and provide guidance or encouragement for investigators to consider where their work might fit. AHRQ conducts "concept reviews" of a three- to five-page "mini-grants." Based on these submissions, project officers work with investigators and make suggestions regarding the applications or other potential funding sources. If NCIPC elects to use the approach of a smaller grant for more innovative research, then they should publicize this option.

Dr. Bernard Auchter agreed that hard priorities can discourage people. In the NIJ's broader research program, that is, RFAs that are not earmarks or evaluations of programs, they suggest certain priority areas, but include an addendum to the effect that if an investigator has another idea, then the investigator should defend the idea and state why it is of critical importance. This element allows other projects that are related to a goal area to be funded and keeps the agency's funding options open.

Ms. Weiss said that recommending that investigators seek funding from other agencies is an opportunity to build partnerships with other agencies. Her Prevention Research Center's priority will be the evaluation of violence prevention programs, which does not fit with NCIPC's three priority areas, but is practical research as opposed to pure research and will have impact.

Dr. Redfern asked NCIPC staff to share their ideas regarding potential negative fallouts from prioritization.

Ms. Galaska said that the Center has diverse stakeholders and asked the group to discuss potential political fallout from advocates for various aspects of injury prevention and control as well as fallout from politicians who already support certain injury issues.

Dr. Redfern asked whether certain programs that are currently supported will no longer be supported. **Dr. Arias** answered that they have not decided not to support programs. Their approach to these issues is developmental. Setting priorities is difficult because all of the Center's work is important and needs to be done. They are concentrating not on which topics are most important, but on which topics can be focused on now and which topics can, or should, wait. Unless they are told that they have to cut programs, the Center's will continue its ongoing work and select areas for heavy focus in order to move the injury prevention field forward.

Dr. Redfern understood that the Center would continue its current work, possibly making cuts if necessary, but keeping the work alive. **Dr. Arias** agreed, adding that a possible strategy could be to follow Dr. Auchter's suggestion to include flexibility for funding strong work that has cross-cutting effect and will make a contribution. The Center wants to assure the field that the priorities do not mean that the Center is no longer interested in other topics or types of research.

Ms. Fingerhut suggested that "a positive spin" needed to be added to why the three priority areas were chosen. The Center should inform the stakeholders, politicians, and advocacy groups about the reasons why the areas are critical.

Dr. Hargarten agreed. The way that the Center frames the priorities can maximize stakeholders' attention and investments. Regarding the prioritization process, he asked whether the intramural research would undergo a prioritization similar to the extramural research. While the Center can control the intramural research program, the extramural research might require a different approach because the work is investigator-initiated and located in academic centers and universities scattered throughout the country.

Dr. Arias agreed that prioritization regarding external work is a challenge, both in setting priorities and in creating the research agenda. Their efforts in focusing are thematic in that they rely on translational research to move the field forward. To achieve these ends, they will narrow the kinds of proposals that they solicit.

Dr. Hargarten noted that if the Center hopes to have outcome results to show in three to five years, then they can prioritize development, intervention, and dissemination work as a priority, since this work has predictable positive outcomes that will move the science forward. Research in basic science, such as defining the problem and risk factors, might be approached differently.

Dr. Fowler expressed concern about the academic and research workforce. People make their careers working in certain fields, and if there is no possibility of funding in these fields, then the workforce could suffer. Further, focusing on certain areas might result in a shift in the workforce toward those areas in order to sustain their careers. To avoid these consequences, they might consider designating an "innovation" funding stream. Without a specific mechanism for funding proposals outside the established criteria, then it is not likely that other projects will receive attention. Another concern is that academic researchers are not coming into the field because it is difficult to get funded and to build a career. She suggested incorporating pre-doctoral and doctoral funding into their approach. If this funding is available in 2008, then students who are thinking about their dissertation work may instigate projects in cross-cutting areas. These types of funding are affordable.

Dr. Guerra noted that the Center will experience fallout from both the prioritization of the three topic areas and from prioritizing within the areas. This fallout could be avoided by calling the topics "areas of concentration" rather than "priorities." Calling a topic a priority implies that another topic is not a priority. If sufficient evidence is available to move to translational research in the areas, then the Center can make a case for concentrating on them to have effects. Their methods for prioritization should be transparent and, as Dr. Auchter suggested, include a means for funding innovative ideas. Finally, she agreed with the concept of adopting a stream for innovative work, whether it is based in public opinion or in a researcher's work.

Dr. Mabry-Hernandez echoed the importance of investing in newer investigators.

Ms. Moyer asked for clarity that the "innovation" stream is within the existing budget to fund research and not taken from other existing programs.

Dr. Redfern agreed, but wondered whether the science was ready to move to translational research and dissemination in all of the priority areas. For instance, in falls prevention, NCIPC began with fundamental research, and the progression to dissemination took a long time and required a "vision." He hoped that they would not assume that other agencies would do the fundamental work.

Dr. Arias clarified that they do not assume that other agencies will do the fundamental work, but they can move toward that model. If other agencies could compliment where NCIPC would like to go, then areas with limited resources can be addressed.

Dr. Frankowski said that the Center has responsibilities in the immediate areas of concentration, but also toward the long-term goal of building the field through means such as its dissertation awards.

Dr. Brown recalled an NIMH review of the value of training programs at the pre-doctoral level. This review found that individual-level awards were the most valuable. This finding represents an opportunity to expand the relatively inexpensive dissertation awards. **Dr. Fowler** commented that her students want to do doctoral work in injury, but there is no funding for their research.

Dr. Hargarten reflected on NIH's T35 program, which funds biomedical research support for medical students. This program has attracted students to biomedical research, and he hopes to attract them to training in injury control research. Investing in students means that their careers in medicine will be leveraged for injury control, regardless of their chosen specialty. Without these outreach efforts, injury will not be visible. A robust training mechanism stems from infrastructure and builds infrastructure. Within the NCIPC priorities, they want to maximize their infrastructure and investments in youth and elders. They do not want to turn away potential stakeholders and collaborators, so flexibility is important.

Ms. Galaska asked for additional negative implications. **Dr. Hargarten** said that negative influences from an external stakeholder can adversely affect the Center. Public stakeholders are allies in seeking funding.

Mr. Reed said that the evidence base was instrumental in advancing the priorities. However, if they wait for the evidence base to catch up in other areas, then they could miss opportunities. Then, external stakeholders could be left with the impression that CDC "missed the train." Other areas in the injury agenda could be "hot topics" that merit response, and not responding to them could have a negative impact on the Center's credibility.

Dr. Fowler said that they have to focus on research, but they must move toward programs with enough resource engagement and intensity to make a difference. Without these programs, then they will never be able to establish that the foundational and translational work leads to the ability to save lives.

Ms. Galaska said that NCIPC stakeholders include researchers and potential researchers as well as members of Congress and advocates. She asked the group to identify other stakeholders, address their potential concerns about the prioritization, and discuss ways to reach out to them.

Dr. Mabry-Hernandez said that their other stakeholders included advocacy groups and professional organizations, which have great impact. She suggested including stakeholders early on so that they are not surprised by the changes, lessening potential negative impact.

Mr. Reed said that the media should not be overlooked as a resource. The media can misrepresent the magnitude of the problem, but the media also represents an opportunity to inform the public.

Ms. Galaska said that the Center could make plans not only to anticipate negative reactions, but to garner positive support and gather champions for their efforts. **Mr. Reed** agreed, echoing a previous point about focusing on health and wellness. Discussing these issues in the positive light of "living well" could build support.

Dr. Hargarten concurred with the concept of engaging outside organizations and framing the priorities positively. Under-represented stakeholders include trauma centers. All trauma centers are obligated to do injury prevention, but not all hospitals are aware of the Center's programmatic efforts. The American Hospital Association could be a strong, positive partner as they address overcrowded trauma centers and emergency rooms, which are public health problems in their communities. He suggested that NCIPC pay heed to how the media treats the release of the IOM Report on Emergency Care and to how the nation views the Report. The Center can offer credible alternatives to help alleviate the problems noted in the Report.

Mr. Huber was not sure whether the Center considers the media to be a friend or a distraction. He referred to a recent accident suffered by a professional football player who was riding a motorcycle without a helmet. Some part of CDC should have issued a press release after this incident, which represents an opportunity to disseminate information.

Dr. Fowler said that discussions have centered around whether role models such as professional athletes have a responsibility to behave in a manner that promotes the health of their fans. Another example of using the media was when the pop star Britney Spears was photographed driving a car with her baby in her lap, unsecured. The information about this incident was often accompanied on the Internet by links to resources about child passenger safety. **Mr. Huber** noted that these ideas are not more important than their primary research goals, but represent opportunities to spark their work and have an impact on the public's health.

Ms. Fingerhut pointed out that CDC has a National Center for Health Marketing, which could fulfill this role. **Dr. Arias** said that for a long time, the media was perceived as a potential enemy, but this relationship is changing. CDC is working to educate media about what the agency does. The Center should be able to respond to opportunities creatively. Further, they help local communities work with, and reach out to, their local media.

Dr. Frankowski pointed out that the Acute Care Injury Research Agenda was unveiled in Denver in May 2005 and was endorsed by a number of professional societies. It was assumed that NCIPC would take a leadership role in research in acute care. If the Center declares new priorities, then he wondered how the Acute Care Injury Research Agenda fits into the puzzle.

Dr. Hargarten felt that the Center should carefully frame the priorities in the context of a dedication to prevention and acute care rehabilitation. Within that focus, the Center is prioritizing dissemination intervention research with concentrations in the three selected areas. This message indicates that CDC is a leader in this area and will build on the important work of the acute care agenda, which includes the care of mass casualties, an area of interest for many federal agencies.

Mr. Reed said that the inability to respond quickly to needs implies that the prioritized agenda is too rigid. From a public perspective, the relevance of CDC leans toward such issues as bird flu and anthrax. As the nation's public health agency, CDC must be able to respond to these issues and to issues in injury prevention and control to build the agency's profile and relevance.

Dr. Fowler pointed out that the public is outraged by the ongoing death and disability as a result of the Iraqi war; however, the United States military loses more service people to unintentional injury than in wars. The military is aware of the dangers of motor vehicle crashes and suicide, but the American people may not be aware of this context.

Dr. Hargarten noted that the first federal grant for injury research was made to Cornell University in 1953 to examine deaths of Army personnel in car crashes. They have an opportunity to leverage this field for more resources.

Dr. Fowler recalled that SPRS discussed moving toward a system of uniform abstracts. Given that NCIPC is responsible for research, programming, and advocacy, she wondered whether the final report for each grant and program should include a "so what" piece; that is, the summary of the work should address how the work pertains to the field and the future of the field. Ultimately, the Center could build a body of experience to inform future work.

Dr. Heinemann said that such an effort would be tied to the logic model, including short-, intermediate-, and long-term outcomes.

Dr. Redfern noted that to some extent, the "so what" is included in the grant proposal itself. The Center will need to devote resources to gathering the "so what" information after the grant has ended, and the information needs to be synthesized by the Center.

Dr. Fowler said that she has found success in asking grantees what did not go as well as expected, what they would never do again, and what worked well and is worth repeating. It is nearly impossible to publish negative findings, so they need a way to assess what does not work.

Synthesis of Discussion

Ms. Louise Galaska, Deputy Director
National Center for Injury Prevention and Control (NCIPC)
Executive Secretary, Advisory Committee for Injury Prevention and Control (ACIPC)

Ms. Galaska summarized the discussion. A dominant theme was that as the research agenda be focused, it is critical that the Center investigate the status of work in the larger environment. This work will yield discrete criteria for their prioritization process and also provide a comprehensive picture of the field and lead toward collaboration. Further, all stakeholders must be considered, including the public, researchers, potential researchers, and policymakers as well as other federal agencies. Thirdly, the Center should pay attention to framing and marketing their efforts. A comprehensive approach will include marketing to a variety of stakeholders using a variety of methods.

Discussion Points:

Dr. Redfern reiterated that the Center should be clear regarding what "priority" means so that stakeholders do not assume that areas that are not designated as "priorities" are not excluded from the Center's work. **Ms. Moyer** suggested the term "areas of concern." **Dr. Guerra** felt that "concentration" is a better word.

Ms. Weiss noted that the Center should be able to take advantage of opportunities and emerging issues. The ability to share information quickly will contribute to this response.

Dr. Guerra recalled discussion regarding a balance between concentration and innovation.

Dr. Hargarten commented on the importance of stimulating cross-cutting cross-applications and collaborations, such as a recent effort of NIH and the National Institute for Aging. For instance, a concentration on elder falls has implications for the home environment as well.

Dr. Tate hoped that the Center will integrate its new goals and efforts with work that has already been done, such as the Acute Injury Care Research Agenda.

Dr. Guerra said that they need to remember the outcome of ultimately reducing injury.

Dr. Hargarten returned to the logic model as their guide. He wondered whether their collaborative efforts could include a centralized means for identifying potential collaborators that are externally funded. For instance, if the Center had a website portal to list its researchers, communication could be fostered and lead to team research.

Dr. Frankowski emphasized the importance of preparing for the next generation of researchers in injury.

Ms. Galaska thanked the committee for their help and participation.

Public Comment, Wrap Up, and Adjourn

Dr. Carolyn Fowler
Johns Hopkins Bloomberg School of Public Health
Chair, Advisory Committee for Injury Prevention and Control (ACIPC)

Dr. Fowler opened the meeting for public comment. Given that no public comments were offered, she thanked Dr. Arias and her team at NCIPC for their leadership and stewardship of limited resources. Further, she thanked Ms. Galaska and Ms. Harris for creating the meeting's agenda and for restructuring the meeting so that it includes opportunities to answer NCIPC's questions and to contribute to the Center's issues. She thanked the staff who helped plan the meeting and ACIPC members for their participation.

Dr. Ileana Arias, Director
National Center for Injury Prevention and Control (NCIPC)

Dr. Arias commented that although "times are hard," times are always hard. NCIPC must address and cope with these times. Addressing obstacles innovatively will lead to the ultimate success of the field, and NCIPC is committed to identifying ways to make the field more successful. She thanked ACIPC for its willingness to work constructively with the Center. The process is difficult and includes potential fallout, which must be honestly considered. Their discussions had been informative, and she expressed her hope that they could include a follow-up regarding the development of the process at the next ACIPC meeting. She thanked them for their time and sustained effort.

With no further business posed, the 47th meeting of ACIPC was officially adjourned at 11:30 a.m.

Committee Members Present:

C. Hendricks Brown, Ph.D.
Carolyn J. Fowler, Ph.D., M.P.H.
Ralph F. Frankowski, Ph.D., M.P.H.
Nancy G. Guerra, Ed.D.
Allen W. Heinemann, Ph.D.
Sheryl L. Heron, M.D., M.P.H., F.A.C.E.P.
Chester Huber
Fuhzong Li, Ph.D.
Diane E. Moyer, J.D.
Mark Redfern, Ph.D.
Jerry Reed,
Denise G. Tate, Ph.D., ABPP
Billie P. Weiss, M.P.H.
Flaura K. Winston, M.D., Ph.D.

Federal Agency Experts Present:

Marilena Amoni, NHTSA
Bernard V. Auchter, National Institute of Justice
Cheryl A. Boyce, Ph.D., National Institute of Mental Health/NIH/DHHS
Richard Compton, NHTSA
Lois A. Fingerhut, M.A., National Center for Health Statistics
Iris Mabry-Hernandez, M.D., M.P.H., Agency for Healthcare Research and Quality
Carol E. Nicholson, M.S., M.D., FAAP, National Institutes of Health
Ted Searle, Substance Abuse & Mental Health Services Administration

Liaison Representatives Present:

Lisa Dawson, Georgia Department of Human Resources
Stephen Hargarten, M.D., M.P.H., SAVIR
Susan Hardman, STIPDA

Committee Members Absent:

Ivan Juzang

Federal Agency Experts Absent:

Nancy Bill, M.P.H., Indian Health Service (IHS)
Jacqueline Elders, Consumer Product Safety Council (CPSC)
John Howard, National Institute for Occupational Safety and Health (NIOSH)
Lynne Haverkos, M.D., M.P.H., National Institutes of Health
Nancy A. Stout, Ed.D., National Institute for Occupational Safety and Health (NIOSH)
Hal Stratton, Consumer Product Safety Council (CPSC)

Liaison Representatives Absent:

Beth-Ellen Cody, National SAFEKIDS Campaign
Ronald M. Davis, M.D., American Medical Association
James C. Helmkamp, Ph.D, M.S., SAVIR

CDC Personnel:

Ileana Arias, Ph.D.
Grant Baldwin, Ph.D., M.P.H.
Christine Branche, Ph.D.
Kendall Cephas, M.P.H.
Geneva Cashaw
Gwen Cattledge, Ph.D., M.S.E.H.,
Adele Childress, Ph.D.
Dianne Clapp
Carme Clavel-Aracas, M.D., M.P.H.
James Enders, M.P.H., C.T.R.
Louise Galaska, M.P.A.
Melissa Gipson

Corrine Graffunder, M.P.H.
April Green
Rodney Hammond, Ph.D.
Amy Harris, M.P.A.
Rick Hunt, M.D., FACEP
Yvonne Jennings
James Mercy, Ph.D.
Brandi Meriwether, M.P.H.
Daphne Moffett, Ph.D.
Cathy Ramadei
Reneé Ross
Richard Sattin, M.D., FACP
Traci Simpson
David Sleet, Ph.D.
Paul Smutz, Ph.D.
Judy Stevens, Ph.D.
Linda Valle, Ph.D.
Marsha Vanderford, Ph.D.
Rick Waxweiler, Ph.D.
Jennifer Wyatt, Ph.D.

Others Present and Affiliations:

Michael D'Anthony, Sound on Site (Sound Technician)
Jim Evans, Sound on Site (Sound Technician)
Andrea Hachat, Maximum Technology Corporation (Contractor)
Tiffany King, Cambridge Communications (Recorder)
Kendra Myers, Cambridge Communications (Recorder)
Carol Peterson, Cambridge Communications (Recorder)
Amber Williams, STIPDA
Tammara Jenkins, NIH/NICHD

Certification

I certify that, to the best of my knowledge, the foregoing summary is accurate and complete:

Carolyn J. Fowler

Dr. Carolyn Fowler, ACIPC Chair ***Date: August 31, 2006***